Postcards from the people: a dialogue model for community needs assessment

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Abstract

There is a growing focus in rural and regional health care on ensuring that priority setting and planning is based on democratic processes and formal community needs assessments. The latter, however, can pose major technical, logistical and resource issues for small rural health services. The paper reports on the trialling of an alternate approach to the major periodic needs assessment based on establishing a formal process of continuous open dialogue between services and their communities.

The model consists of three elements: a 'postcard' data collection system, a data management and action system, and a feedback dissemination model.

The postcard data collection is designed to systematise and formalise the capture of what would normally be called 'anecdotal' data. That is, comment that arises informally and spontaneously in the course of day-to-day community interactions, especially those around service delivery encounters. Such data, even if captured, normally have little or no standing within the formal processes of community consultation because the lack of methodological rigour is seen to compromise validity. Yet, these data can be superior in many ways—volume, authenticity and the breadth of sample represented—to that generated in even the best formal data gathering exercise. By maximising the accessibility and simplicity of the community input process—using a simple postcard feedback system with very informal input protocols—while formalising and systematising the capture and management of these data, the model preserves the breadth and quality of the data while enhancing their rigour, validity and strategic value.

The second element, a data management and action system is designed to ensure that every instance of community input is treated with full respect and subject to appropriate action and feedback, regardless of its weight, the status of the contributor or the service's ability to respond in the way desired.

The third element of the system is a dissemination and communication approach which seeks to build trust and develop a dialogue with the community by responding publicly, promptly and specifically to all community input.

The model's focus on a set of principles—systematising the capture of 'anecdotal' data and demonstrating respect for all community input through a rigorous system of data management and extensive and timely feedback—rather than on fine methodological prescription, makes it adaptable to a wide range of contexts.

Introduction

The principle that communities should be involved in shaping their local health care services and priorities is now firmly entrenched in primary health care and government policy in Australia (1, 2) and the United Kingdom (3–5). As part of this, community needs assessment has come "to be seen as integral to the process by which primary care responds to local and national priorities." (6 p. 695). At least two of the Australian Government's major rural health support schemes, Regional Health Services and Multi-purpose Services, mandate a high level of community involvement in service design and priority setting (7).

While the ideal is rarely questioned, there are major issues in translating principle into practice.(3, 6, 8–10). These include problems in conceptualising and prioritising need, logistical and methodological difficulties compounding shortfalls in skills and resources, and negative perceptions and resistance among health organisations and professionals. A new model is proposed that addresses some of these

issues by using the systematic collection and management of anecdotal data to establish an ongoing dialogue between community and health service.

Conceptualising need

A large part of successfully involving community in shaping health services relies on finding a credible way of measuring community health needs. Luker and Orr comment that "the issues and debates surrounding the definition and measurement of need are far from resolved." (11 p. 110). If we accept their claim that needs are social (that is, a social construct tied to community values and meanings), relative (varying between individuals and groups) and evaluative (the product of value judgements), resolution of definitional and measurement issues in the sense of an objective finality is a logical impossibility. Theoretically, any resolution will simply be a dynamic point of balance within an ongoing social process, when tensions between different values and meanings, agendas and judgements reach some form of (temporary) accommodation. Practically, it means that whose, and which, issues get defined and prioritised as need will depend on whose views and interests prevail at that point within an inevitable ongoing social 'struggle' over the distribution of perennially scarce resources (12). Bradshaw's enduring typology of felt, normative, expressed and comparative need (13) is useful here in at least sensitising those involved in needs analysis to the range of interest and agendas that need to be brought into some sort of balance.

An important consideration is the extent to which the needs assessment process is a struggle marked by conflict and the exercise of power and influence, or a negotiation marked by dialogue grounded in trust, mutual respect and a desire for equity. While the latter sits more comfortably with the principles of community priority setting, the use of power and control to force faster and more decisive outcomes has some bureaucratic and organisational advantages over the more time consuming processes and fluid outcomes of a dialogic approach. However, there is no reason why the latter, once fully implemented and functioning, cannot deliver timely outcomes with acceptability and credibility to both community and professionals. It also can ease some of the major barriers to the incorporation of principle into practice. The two most frequently identified barriers are resource issues and organisational and professional resistance.

Resource issues

Running a comprehensive and rigorous community needs assessment requires considerable time, skill and money putting it beyond the resources of many community health providers (4, 6, 10, 14, 15). The current focus on the quality of evidence used as the basis for practice (16, 17) presents particular challenges in the area of policy and service delivery where random trials can be infeasible and inappropriate and social science methodologies predominate. While there is no question that sound qualitative methodologies can yield quality evidence, the particularly complex parameters for qualitative research rigor can present a major problem for services with limited resource trying to assemble evidence of sufficient scope and credibility to justify continuing program funding. It is further complicated when funding agencies also mandate wide community involvement in the evidence gathering process. For many health service organisations the perceived size of the task and high skill requirements appears to leave little option but to hire outside consultants for this task.

This in turn has major disadvantages. Firstly, it is expensive, a problem compounded where programs face strict limitations in the monies they can divert from direct service provision towards community needs assessment. Secondly, it usually involves periodic one-off exercises run to tight deadlines over a short time frames using out-of-community data gatherers. Although there is community consultation it generally falls short of community involvement in the full sense of an ongoing dialogue between community and service around needs. Such a dialogue requires some process for continuous, or at least frequent monitoring and measurement of changing need through a system of ongoing data collection. The challenge is to find a model that meets these aims within resources and without compromising data quality. Opening up dialogue would also go some way to addressing the other major barrier of organisational and professional resistance.

Organisational and professional resistance

The largest obstacle to translating principle into practice in community shaping of health services is organisational and professional resistance to change (4, 8, 11, 15, 18, 19) . Needs assessment that is undertaken without clear commitment to change can become "ritualistic and self-justifying" (18 p.473) and rapidly exhaust community goodwill. The reasons for resistance are not hard to find. Within health services, there is always more need than resources to meet that need. For most, "the more comprehensive the assessment, the more inevitable the possibility that a plethora of social needs will be revealed that providers are unable to act upon, resulting in universal disillusionment . . [and] . . frustration." (4 p.727). Also, any tensions between community (felt and comparative) and professional (normative) assessments of need challenge hard-won professional knowledge and control (3, 4, 15). This can lead professionals to mount a defensive challenge to the quality of any evidence which does not accord with existing organisational goals and priorities. (18) Wutchiett et al. found that:

> Agency administrators viewed assessment data primarily as a means of justifying existing services and of obtaining funds for the expansion of services. . . . [not] . . . as a means of evaluating and redirecting existing services and resources. [Barriers to the constructive use of assessment information] included defensiveness, a lack of understanding of what the data meant and a challenging of data which were not consistent with current agency resources and interests.' (19 p.58)

The problem for service providers is that without additional resources, every unmet need that makes it onto the priority list displaces another off that list and dropping any service is never easy to sell to the community.

Hawe (18) suggests precipitating change by abandoning broad balanced consensus approaches—which tend to perpetuate the status quo—in favour of ones that are "more narrow, focused, value explicit and change driven." (p. 477) While accepting Hawe's thesis that it is necessary to lay open "essential conflicts" (p.475) in order to precipitate change, her approach would seem to be, at heart, adversarial with an implicit basis in power struggle and win-loss outcomes. While this approach may well have its place on certain issues, the risks of exacerbating resistance and division would seem to limits its potential role within an overall strategy of community involvement.

The failure of needs assessments to open up and manage 'essential conflicts' likely flows from the fact that most simply do not incorporate structures and process able to facilitate, in any meaningful sense, the sharing and discussion of ideas and values that would be needed to 'lay open', and resolve, tensions and conflicts arising from the mismatch between resources and need. That is, from designs that do not encourage or support dialogue.

Establishing dialogue

The Concise Oxford Dictionary defines dialogue in terms of 'a conversation' and 'an exchange of ideas' (20). Needs assessment as generally practiced hardly fits either definition, with limited exchange and even less conversation between the parties. For community, any sharing of ideas is limited to a one-off (or at best periodic) one-sided 'collection' process occurring in a highly structured, formal and time limited context at one step removed from the actual service providers. The community is likely to have to glean service provider views by implication from existing service profiles and changes, or lack of them, flowing from the assessment process. This makes for a high risk of misinterpretation and misunderstanding.

Dialogue is something altogether much richer, more informal and relaxed, more balanced, inclusive and ongoing. It can facilitate a prolonged negotiation and accommodation of views, meanings and agendas without wearing people down; a factor Hawe (18) associates with failure of many needs assessments to disturb the status quo. It has the capacity to smooth resistance by reducing the potential for polarisation and promote incremental rather than precipitate change. The proposed model takes some practical steps towards this ideal.

A Dialogue Model of Needs Assessment (Figure 1)

The model seeks to meet three goals: a dialogic process, quality evidence and modest resource requirements. Conducting a comprehensive needs assessment can be compared to doing a jigsaw puzzle. If it is to take account of all four categories of need (13) it will requires fitting together different forms of data from multiple sources (6, 9).

Measuring expressed, comparative and normative need

In terms of expressed need, comprehensive, searchable databases of service delivery and usage are now widely used is a basic tool of service planning and quality assurance and should not be beyond the resources of even the smallest community service. Similarly, developments in free web-based access to reports and aggregate data have considerably eased the task of gathering data that speak to comparative and to some extent normative need. Small numbers and easy accessibility also make it feasible to gather normative data from key health professionals one-on-one. The major challenge lies in accessing quality data that address felt need.

Measuring felt need

Felt need is what the community identify as need when asked. For this, surveys are generally seen as yielding the best data for a given expenditure, although it can require considerable (expensive) effort and a sophisticated methodology to reach a fully representative community sample. Also, unless very cleverly designed, the manner in which surveys define agendas and condition responses runs significant risks of producing skewed data (21).

In contrast, the proposed postcard dialogue model focuses on capturing comment and opinion arising spontaneously in the context of everyday interactions. It is predicated on the assumption that within any community health service, important conversations about service quality and service priorities are occurring all the time during day-to-day service and community encounters. While these data may be fragmented and focused on a single issue, they have the advantages of immediacy and context and are largely unconditioned by any sense of what is the 'right' response. This gives them, in at least one sense, superior claims to credibility and validity to survey data. While these data do find their way into the service planning process through their effects on the views of reflexive practitioners, their role within the organisational process is generally invisible and unacknowledged because it is not systematically captured and formally incorporated. They are dismissed as evidence because they are 'anecdotal', in essence because each piece of data exists in isolation; samples of one.

Systematically and comprehensively captured, these data would build over time into a representative high quality data set around the community's felt needs. They would then provide an excellent basis for community-service dialogue around health service needs, priorities and quality. The proposed model involves three elements: a method of capturing day-to-day anecdotal data, the formal, rigorous and transparent management of those data within quality assurance and planning processes, and the establishment, using those data, of a process of ongoing and open dialogue between the service and the community. It operationalises three principles: that spontaneous day-to-day reactions to health services represent an accurate and reliable measure of felt need; that building trust requires according every comment equal value and equal treatment and that establishing dialogue requires openness, commitment and contribution from both parties.

Element 1: A postcard model for capturing expressions of felt need

The systematic capture of day-to-day comments requires a methodology and/or instrument that is so accessible, user-friendly and convenient that its use becomes routine for everyone from the humblest community member to the top of the health service. It must make fewest possible demands on individuals' literacy skills, time and minimise disruption to the day-to-day routines of life and practice. A postcard represents one possible way of accomplishing this.

The suggested instrument is a standard replied-paid postcard with the service address on the front and on the reverse a simple invitation—e.g. 'Do you have something you would like to tell us?'—and space

to contribute comments of any sort. An colourful design reflecting—and perhaps designed by—the community would increase community ownership, acceptability and visibility.

It is crucial to the success of the model that the card become the standard instrument for all feedback to, and within, the service. Contributions would be anonymous (identified by collection point only), and informant as well as first-hand contributions would be welcomed. No conditions would be put on the form or nature of acceptable data with all—from learned to the abusive—accorded equal respect and treatment within the system. This is seen as essential in building trust and confidence. The card would need to be ubiquitously available within the community and the health service and possibly include a range of forms to suit different users—including internet-based. Once established, ongoing maintenance of such a system should require only a modest resource commitment.

Data quality

The major threats to data quality arise from bias (within sampling, measurement and interpretation) and inappropriate generalisation (22, 23). With comprehensive and systematic capture and collation, these data should, over time, build a larger sample with less selection bias than one generated by one-off survey. The spontaneous and unstructured nature of the data is likely to mean less measurement bias and risk of misinterpretation than occurs with researcher designed instruments. This is however, entirely dependent on developing an instrument, system and associated culture that maximises the capture of comments across the widest range of individuals across the widest range of issues.

Element 2: Data management and action

Good research practice dictates that all data be treated with respect and managed with systematic integrity. Ethical standards (24) dictate that those who contribute data can expect they will be used in ways that accrue benefits that justify their contribution and that they be properly informed of the research outcomes (25). These considerations are pivotal to the model

The system of data management and actioning is designed to minimise resource requirements, ensure that all data are equally attended and actioned and maximise dissemination and communication. The administrative detail in less important than adhering to the following principles:

- Regardless of their nature all inputs are recorded, considered, responded to and the outcomes reported back to the community. In order to build trust and respect for the process this may mean treating frivolous or abusive data seriously, and openly acknowledging, as part of the dialogue process, when needs cannot be met.
- To simplify the process all data flows are managed through a single point with only the minimum necessary detail recorded on a simple database with automated 'one-button' report macros (Figure 2).
- All data are seen and reviewed by management at a level able to act on any required responses or decisions.

The model's success is dependent on full integration into the day-to-day workflow, quality and service review practices and culture of the service. In order to establish true dialogue, however, the service also need to maintain their side of the conversation.

Element 3: Establishing dialogue—communication and dissemination

Needs assessments that raise needs that services cannot meet—even where these needs are acknowledged and priorities supported—can draw protective reactions from providers (3, 6). Unless openly explained, these reactions, or worse, silences, can lead to a loss of trust and commitment to contribute (4). It is suggested that the establishment of an open and ongoing dialogue between community and service hold the key to a successful needs assessment process.

Dialogue requires respect for contribution from both sides. If the service shows that respect by the way it not only manages every contribution from the community but by keeping the community informed in detail; reporting on actions taken, contemplated, deferred or ruled out and the reasons behind these decisions. Or, in some cases, simply a public acknowledgement of a voice heard and the invitation to continue the conversation. The assumption is that trust is not about meeting the other party's every wish but in engaging; equally, honestly and openly.

The mix of available dissemination and communication avenues will vary from community to community. The primary instrument suggested is a regular report sheet containing a summary of data received in the preceding period and details of responses and any action in regard to those, or other earlier data. This would be available at multiple public points within the service and the community. Ideally such points would become 'conversation points' by also providing blank cards and a sealed return box for completed cards. In addition, most communities have some a range of public media—community newspapers, radio stations, notice boards—through which regular reporting could occur. The keys are regular, open and accessible dissemination.

Trailing the model

Efforts to trial the full model, are under way. While a number of communities have picked up individual aspects of the model, these trials have not been established long enough to be properly evaluated at the time of writing. Getting a full trial up and running involves overcoming a number of hurdles. These include the long time lag in getting the system properly established, mismatches with prevailing bureaucratic, professional and perhaps community culture and the necessity for a community-wide focus. Taken together these add up to a leap of faith and some level of risk for any service adopting the model. A full trial will, therefore, most likely need to be at least partially separately resourced.

The postcard dialogue model will not approach, let alone exceed the efficiency and effectiveness of existing survey approaches until such time as it becomes firmly embedded and trusted within the culture of both the community and the service. Only then, when all parties see this as a legitimate and effective tool for the sharing and negotiation of views and values, will the quantity and quantity of the captured data be sufficient to be accepted by all parties within and outside the community as a credible alternative to standard needs assessment. This is a complex social undertaking and will take time, especially in overcoming resistance, on one hand among health professionals and funding organisations who question the credibility, reliability and validity of the data and on the other among community members who question the value and effectiveness of their input in bringing about change. Such an open and unregulated system of data collection will also inevitably raise issues well beyond community health systems and services. For full effectiveness, the model would need to bring on board other service providers since the dialogue once established is likely to widen to encompass the full range of community services.

Conclusion

The proposed model promises a number of advantages over currently used survey-based approaches for capturing community data around 'felt' health service needs. It is designed firstly to eventually deliver a continuous flow of high quality data while making only modest demands on the service's time, money and research skills. These data, and their systematic and thoughtful management, can then provide the basis for building open dialogue through which health services and communities can work together to shape services and outcomes. The key to the model is not in the methodological detail but in the operationalisation of basis principles—systematising the capture of 'anecdotal' data and demonstrating respect for all community input through a rigorous system of data management, action and extensive and timely feedback. Any or all of these principles may be operationalised in other ways and other systems and the author would welcome any community health service interesting in trialling all or part of the model.

Policy recommendations

If funding agencies, in particular the Department of Health and Ageing, are going to continue to make community involvement in service priority setting a requirement for ongoing funding, they need to acknowledge this by building, into their contracts, a specific funding allocation—over and above that marked for service delivery—to support program evaluation and needs assessment activities. The goals and performance indicators around such funding should be tailored to support the longer term development of approaches and models which empower communities to make their own evidence based decisions around health care needs.

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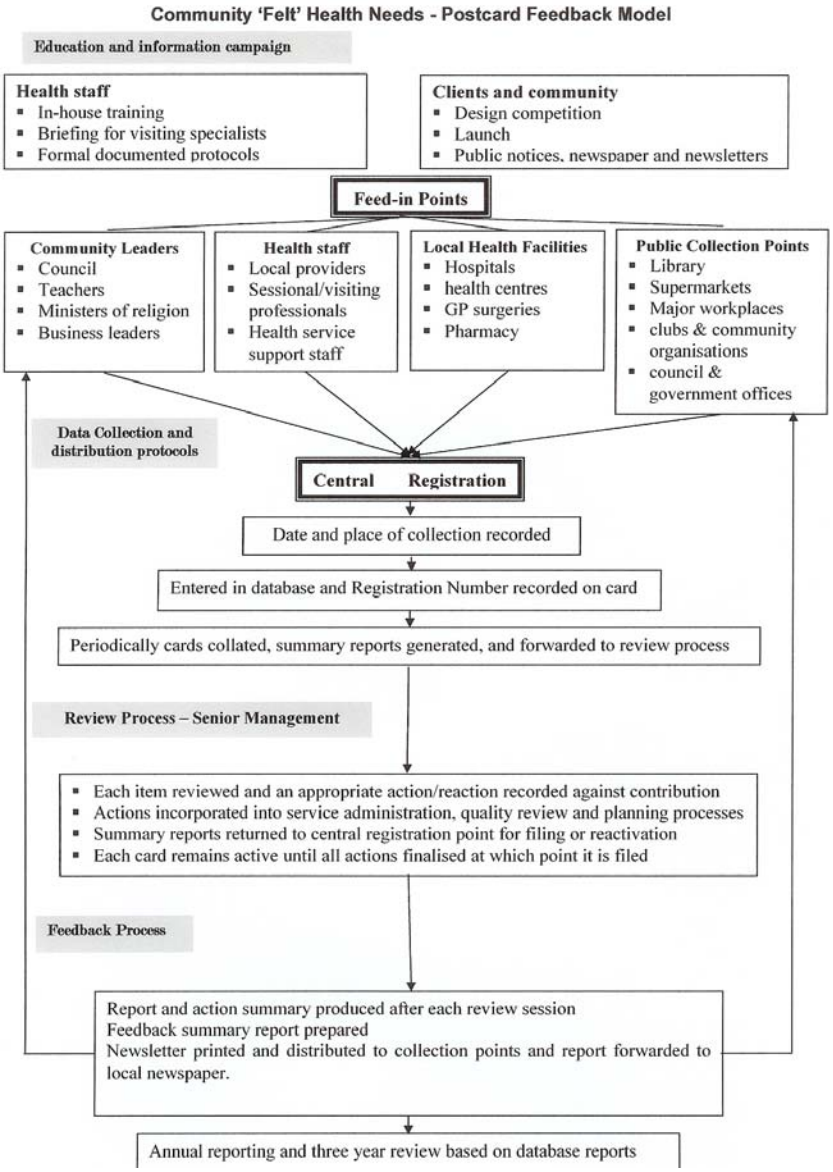
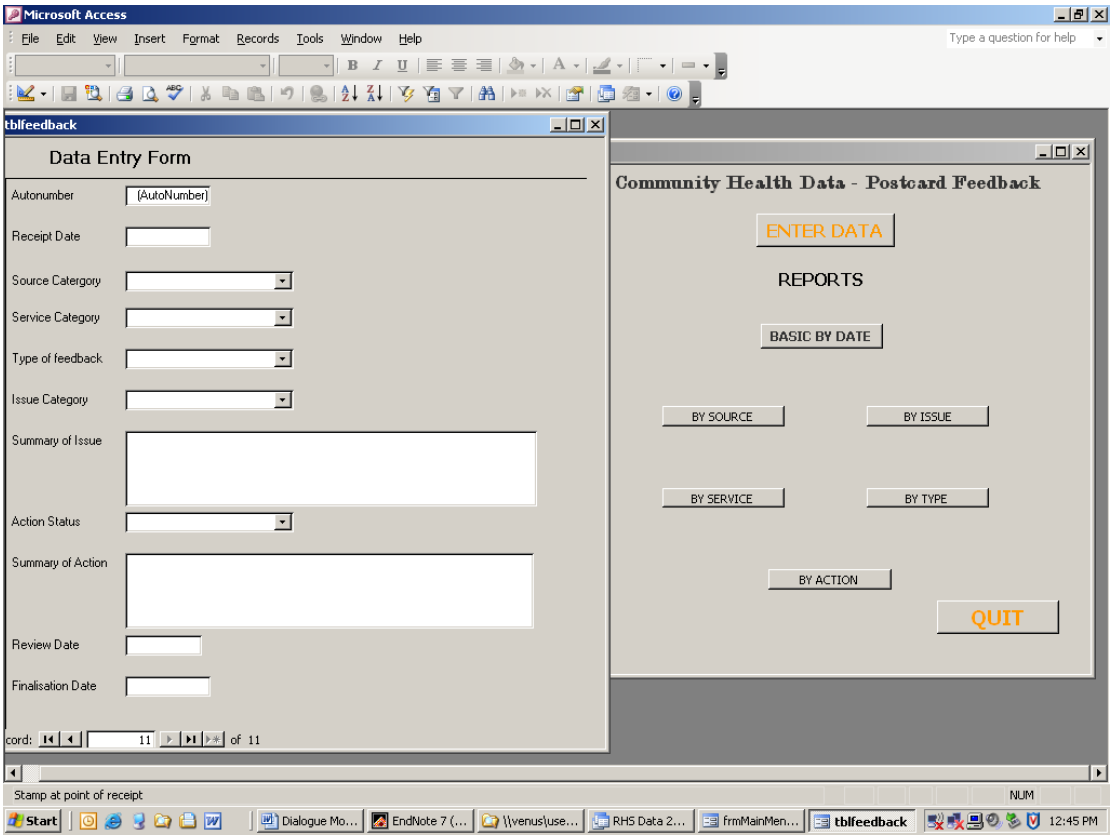


Figure 2 Database entry screens



Presenter

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